

Technical Report
No. 46

Hospital Autonomy in Malawi: Assessment and Implementation Plan

September 2000

Prepared by:

Ibrahim Shehata, MBA, MHA
University Research Corporation

Gil Cripps
USAID/REDSO/ESA



Partnerships
for Health
Reform



Abt Associates Inc. ■ 4800 Montgomery Lane, Suite 600
Bethesda, Maryland 20814 ■ Tel: 301/913-0500 ■ Fax: 301/652-3916

In collaboration with:

Development Associates, Inc. ■ Harvard School of Public Health ■
Howard University International Affairs Center ■ University Research Co., LLC



Funded by:

U.S. Agency for International Development



Mission

The Partnerships for Health Reform (PHR) Project seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- > better informed and more participatory policy processes in health sector reform;*
- > more equitable and sustainable health financing systems;*
- > improved incentives within health systems to encourage agents to use and deliver efficient and quality health services; and*
- > enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

September 2000

Recommended Citation

Shehata, Ibrahim and Gil Cripps. September 2000. *Hospital Autonomy in Malawi: Assessment and Implementation Plan*. Technical Report No. 46. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

For additional copies of this report, contact the PHR Resource Center at PHR-InfoCenter@abtassoc.com or visit our website at www.phrproject.com.

Contract No.: HRN-C-00-95-00024

Project No.: 936-5974.13

Submitted to: USAID/Lilongwe

and: Robert Emrey, COTR
Policy and Sector Reform Division
Office of Health and Nutrition
Center for Population, Health and Nutrition
Bureau for Global Programs, Field Support and Research
United States Agency for International Development

The opinions stated in this document are solely those of the authors and do not reflect the views of USAID.

Abstract

The concept of hospital autonomy originated in countries where central health authorities have primary responsibility for the provision of curative inpatient care in addition to their traditional responsibility for planning and regulating health programs. As the cost of inpatient care rapidly increases, the role of governments in providing inpatient services is being seriously revisited.

In Malawi, the government has made a clear choice to move towards hospital reform starting with the two largest public referral hospitals. This decision was motivated by the increasingly limited financial resources available and by the current state of operational and structural decay of the hospitals. Privatization of the public hospitals is not an option, as it would be perceived by the general population as reneging on the government's past assurances to provide free and affordable inpatient care. A middle course has been chosen by which public ownership of the hospitals will be retained and organizational reforms to induce hospitals to operate more efficiently will be implemented.

Malawi's hospital autonomy strategy is based on a phased approach that ensures systematic implementation. To be successful, many systems and individuals, internal and external to the hospitals, will have to be in place and functioning properly prior to completing the final transfer of authority. The implementation strategy includes three phases, all to be completed in four years.

- > Phase I – Initiate strengthening of hospital systems and outpatient health centers.
- > Phase II – Strengthen the hospitals' operational capacity.
- > Phase III – Complete the transfer of operational autonomy to the hospitals.

Table of Contents

Acronyms	vii
Acknowledgments	ix
Executive Summary.....	xi
1. Background	1
2. Objectives	3
3. Situation Analysis	5
3.1. Organization, Staffing, and Management Structure.....	5
3.1.1. General.....	5
3.1.2. Organizational Structure.....	6
3.1.3. Utilization	6
3.1.4. Staffing	7
3.1.5. Planning and Performance Monitoring.....	9
3.2. Financial Management	10
3.2.1. Organization and Staffing.....	10
3.2.2. Financial Management Training and Staff Deployment.....	11
3.2.3. The Budget System and the Medium-Term Expenditure Framework.....	11
3.2.4. Hospital Workload.....	13
3.2.5. Cost Structure.....	14
3.3. Human Resources Management	15
3.3.1. General.....	15
3.3.2. Creating New Positions	16
3.3.3. Recruitment.....	16
3.3.4. Promotion and Dismissal.....	17
3.3.5. Performance Evaluation.....	17
3.3.6. Staff Development and Training.....	17
3.4. Procurement Management	18
3.4.1. Lilongwe Central's General Stores.....	18
3.4.2. Kitchen	18
3.4.3. Pharmacy	19
4. Conclusion.....	23
4.1. Decreasing Government Financial Support.....	23
4.2. Establishing a Referral System.....	24
4.3. Strengthening the Primary Care System.....	24

4.4. Developing New Sources of Revenue.....	24
4.5. Enhancing Personnel Skills.....	24
4.6. Establishing Hospital Management Systems	25
5. Recommendations	27
Annex A. Implementation Plan.....	29
Annex B: Bibliography	57

List of Tables

Table 1. Number of Staff at MOHP by Facility Type and Personnel Category	8
Table 2. Physicians by Title or Rank Category.....	9
Table 3. Lilongwe Central Hospital Accounts Department–Staff Establishment 1999–2000.....	11
Table 4. Lilongwe Central Hospital Inpatient Workload.....	13
Table 5. Queen Elizabeth Central Hospital Inpatient Workload.....	14
Table 6. Lilongwe Central Hospital 1999–2000 Cost Structure	15
Table 7. Analysis of Drug Purchases at Lilongwe Central Hospital.....	21

Acronyms

CMS	Central Medical Store
DHRMD	Department of Human Resources Management and Development
HR	Human Resources
LCH	Lilongwe Central Hospital
MK	Malawi Kwacha
MOHP	Ministry of Health and Population
MTEF	Medium-Term Expenditure Framework
OPD	Outpatient Department
ORT	Other Recurrent Transactions
PDE	Patient Day Equivalent
PHR	Partnerships for Health Reform
PSC	Public Service Commission
QECH	Queen Elizabeth Central Hospital
USAID	United States Agency for International Development

Acknowledgments

This report has been made possible through the input of many people who contributed in various ways to the Hospital Autonomy Assessment and Implementation Plan. The drafting team would like to acknowledge the contributions of the following people and organizations.

The Hospital Assessment and Implementation Plan was implemented under the guidance of the Secretary for Health and Population Dr. R. Pendame and the Principal Secretary for Finance and Administration Mr. W.O.O. Sangala.

The authors greatly appreciate the cooperation and information provided by the Department of Health Planning Services at the Ministry of Health and Population, particularly by Mr. Rene Mapemba, the department's deputy director. Mrs. Flora Kanjere and Dr. Mauona Ngwira planned all our visits and gave a lot of invaluable information on the central hospitals and the nature of their relationship with the Ministry of Health.

Special thanks to Dr. Biziwick Mwale, Queen Elizabeth hospital director, and Dr. Charles Mwansambo, Lilongwe Central Hospital director, for their contributions to the information gathering during the initial assessment visit and later for their comments and ideas on the draft report to ensure that it includes all the needed elements to make it doable. Also we appreciate all the hospital staff with whom we met for their time and contribution of information.

Our gratitude to all the department controllers who contributed during the assessment stage and later with feedback on the implementation plan. We are especially appreciative to Mrs. Joan Larosa from the USAID mission in Malawi for her role in initiating the process and securing the necessary funding for the assessment and the development of the implementation plan.

This study was made possible with funding from USAID through PHR project under contract number HRN-5974-C-00-5024-00.

Executive Summary

In Fall 1999, the Partnerships of Health Reform Project (PHR) and United States Agency for International Development's Regional Economic Development Services Office in East and Southern Africa (REDSO/ESA) conducted an assessment of Queen Elizabeth Central and Lilongwe Central hospitals to examine the strengths, constraints, and strategies for building hospital autonomy capacity.

The aim of the assessment was to understand the underlying problems the hospitals face, determine whether these problems pose an obstacle for implementing autonomy, and propose practical yet valid solutions to overcome these obstacles. This requires an implementation plan that takes into account current obstacles and the realities of the existing system while also bearing in mind the possible downside if no serious changes take place.

The assessment indicated that the two central hospitals have limited control over their operations and insufficient financial and human resources. Based on the assessment and other studies commissioned by MOHP, and due to the increasing financial needs of the hospitals, PHR recommends that MOHP move forward with implementing a systematic plan to grant the hospitals operational autonomy.

To achieve autonomy, an implementation plan is proposed that focuses on transferring the decision making authority to the central hospitals with regards to five main administrative and financial functions:

- > Strategic management,
- > Procurement,
- > Financial management,
- > Human resources management, and
- > Administration.

To increase the likelihood of success, given the bureaucratic limitations within MOHP and the sensitivity of the hospital autonomy issue, an independent high-level "executive implementation committee," separate from MOHP, should be created to take full responsibility of all implementation activities of hospital autonomy.

Based on the assessment findings, the team recommends a three-phased implementation plan that addresses existing and potential obstacles and builds or strengthens existing hospital systems in order to realize hospital autonomy. Since this is not an activity that can be implemented within a year or two, the implementation of autonomy is expected consume four to five years during which the hospitals would have established the necessary structural foundation to operate as independent institutions.

The recommended hospital autonomy strategy is based on an integrated, phased approach that ensures implementation in an organized systematic way. To be successful, many systems and individuals, internal and external to the hospitals, will have to be in place and functioning properly prior to final implementation. The integrated implementation strategy includes three phases with multiple activities to

be performed simultaneously. Establishing the proper infrastructure for implementing hospital autonomy will be the focus of the plan. The three phases of implementation are:

1. Initiate strengthening of hospital systems and resources and strengthen the primary sector feeding the hospitals.
2. Strengthen the central hospitals' operational capacity.
3. Complete the transfer of operational autonomy to the hospitals.

1. Background

Public sector hospitals have recently come under intense scrutiny because of their bureaucratic complexity, low standards of care, heavy burden they impose on public funds, and perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy option that has found particular favor with governments is the granting of greater autonomy to these public sector hospitals in running their operations. As a result, many developing countries have proposed “hospital autonomy” initiatives as an integral part of a broader health sector reform process.

In Malawi, the Ministry of Health and Population (MOHP) appointed a Hospital Autonomy Working Group to report on the current constraints facing public hospitals and the need for granting more administrative and financial autonomy. The group’s report, presented in July 1997, gave a general overview of the MOHP hospital system, a description of its existing problems, and the purpose of establishing autonomous hospitals.

A year after the group presented the report, the Partnerships of Health Reform (PHR) project conducted a rapid assessment study of health reform issues. Among other things, the assessment looked into the constraints, strategies, and implementation of autonomy in MOHP hospitals. The assessment identified key activities that will require substantial investment in capacity building at the hospital level for these hospitals to become autonomous. The following key areas were identified:

- > General management;
- > Financial management;
- > Human resources management;
- > Purchasing and supplies management; and,
- > Management information systems.

In addition to forming the Hospital Autonomy Working Group, MOHP has specifically mentioned granting autonomy to two central hospitals in its National Health Plan for the years 1999 to 2004. MOHP subsequently selected Lilongwe Central Hospital and Queen Elizabeth Central Hospital to serve as the pilot facilities for autonomy. Considered to be the largest two hospitals in Malawi, the facilities operate as the main referral hospitals for the entire country. Queen Elizabeth Central, located in Blantyre, serves primarily the southern region, while Lilongwe Central is the only tertiary hospital serving the northern and central regions. A new, 300-bed central hospital was recently built in Mzuzu to serve the northern region, but it is not yet functional. The Hospital Autonomy Working Group estimated that only 10 percent of the health budget is spent on level II and level III hospital care, but that, overall, 50 percent of the total health budget is channeled through hospitals and as much as 30 percent is accounted for by the three central hospitals.

For more than a year, Lilongwe and Queen Elizabeth Central hospitals have been aware of their designation to serve as pilot facilities in the hospital autonomy initiative; however, there has been practically no progress made to start moving them in that direction. With the National Health Plan’s intent of granting autonomy to the two central hospitals by the year 2004, there is a pressing need to formulate a

plan and initiate implementation activities. It was requested that PHR, in coordination with the USAID mission and the Hospital Autonomy Working Group, assist MOHP in the process of planning for implementation at the two central hospitals.

2. Objectives

Hospitals are an integral part of the health care system in Malawi, yet policymakers constantly grapple with hospitals' economic efficiency when allocating resources to alternative activities—primary and preventive care as opposed to curative/institutionalized care—in the health sector. Considering the limited resources available for the various activities, policymakers must decide in which of these health care subsectors to invest, based on perceived need and potential returns on investments in terms of improving patient health status. Government hospitals absorb a very large, and arguably disproportionate, share of the total government health resources in the form of capital infusions, outlays of recurrent expenditures, and various other direct and indirect subsidies. Moreover, there seems to be a consensus among the majority of Malawi's providers and recipients of public hospital services that these hospitals are functioning inefficiently in terms of technical and allocative efficiency. It has been suggested that the government's involvement in the provision of health care has been the major contributing factor to the inefficiencies observed in Malawi's public hospitals. Thus, a movement away from centralized decision making and more toward increasing the level of operational independence at public hospitals has been recommended.

In short, there is wide consensus that public hospitals need urgent reform; however, there is disagreement on how to go about this reform. The first step to move towards realizing some type of consensus was to assess the two central hospitals in Malawi that were selected to serve as pilot facilities. The assessment had the following objectives:

- > Gather baseline information on how both hospitals operate;
- > Understand the main problems they confront;
- > Evaluate existing capacity to increase the hospitals' operational responsibility;
- > Examine the nature of their relationship to the central MOHP and other government agencies; and,
- > Assist with formulating a realistic and practical plan for implementing hospital autonomy at both facilities.

The aim of the assessment was not to provide an opinion on whether or not the hospitals are operating efficiently; rather, the objectives were to better understand the underlying problems the hospitals face, determine whether these problems pose an obstacle for implementing autonomy, and propose practical yet valid solutions to overcome these obstacles. This requires proposing an implementation plan that takes into account current obstacles and the realities of the existing system while also bearing in mind the possible downside if no serious changes take place.

This could mean that because of the deteriorating state of these public facilities, profound changes in the way they provide care may be necessary. This may require proposing solutions that could be viewed as risky; however, the downside of maintaining the status quo would have to be seriously considered before deciding on the direction to follow. The problems in the central hospitals are far more deeply rooted than would be solved by simply granting them more autonomy to manage their own affairs.

These problems are interconnected with a variety of other structural and social issues that may need to be addressed, and they are part of the larger National Health Plan as well.

It appears that a flawed conceptual basis for hospital autonomy is as responsible for failure in implementation as is poor implementation of the autonomy measures. Hospital autonomy generally means that hospitals are at least partially self-governing, self-directing, and self-financing through the generation of revenues from user fees. Autonomy can take a variety of forms, with government-owned, centrally financed and directed hospitals on one end of the spectrum and private, fully independent medical institutions on the other.

A policy of moving Malawi's central hospitals toward greater autonomy does not mean that these hospitals need to be privatized. In Malawi, MOHP's intention is that government hospitals will continue to be state owned. Giving the hospitals some autonomy is a way to empower their management and will allow these institutions to become largely self-directing and potentially self-financing.

3. Situation Analysis

3.1. Organization, Staffing, and Management Structure

3.1.1. General

Lilongwe Central Hospital, with an operating capacity for 980 beds, is the only referral hospital responsible for serving the population in the northern and central regions. Queen Elizabeth Central Hospital, a 900-bed facility in Blantyre, is the primary referral hospital for the southern region. Both hospitals also serve as district hospitals and provide primary, secondary, and tertiary care to their patients.

Lilongwe Central is divided into two campuses that are approximately two miles apart: the old hospital, commonly known as Bottom Hospital, and the new one that comprises the main campus. Queen Elizabeth Central Hospital has been designated a University Teaching Hospital since 1991; however, it remains an MOHP-owned and -operated facility. Both hospitals continue to be almost fully dependent on government financing with a fairly small portion of their revenue generated through user fees collected at the “paying” outpatient department and the “paying” inpatient wards. The paying outpatient department and inpatient wards are usually operating at full capacity, but the impact their revenue has on improving the general quality and conditions of the hospitals continues to be very limited. This is due partially to the small portion that these revenues comprise of the total financial needs of the hospital. Currently, all revenue collected from paying patients is kept for use within the hospitals.

Recently a draft proposal was submitted to the Ministry of Health to expand the user-fee concept across the board to all inpatient and outpatient departments and to increase the amount patients pay for services rendered. If this was to be accepted, one problem that comes to attention immediately is that as long as the actual unit cost is unknown, any effort made to increase user fees will not guarantee improvement in the overall revenue stream and, ultimately, the delivery of care. There is no doubt, however, that any increase in revenue, whether through user fees or any other source, is much needed at these financially depleted hospitals.

Lilongwe Central Hospital’s dental department applies user fees to all services it provides and has an agreement with the hospital to split the revenue generated equally. While the fees charged reportedly comprise a very small portion of the actual total cost of the service, the department’s experiment has so far proved very successful as far as improving the quality of services provided to patients.

Overall, during fiscal year 1997/1998, the budgets for Queen Elizabeth Central and Lilongwe Central hospitals were MK 26,335,893 and MK 22,945,169, respectively.¹ The actual funds received, however, were lower than that due to the “cash budget” system. This means that while the ministry may agree to certain budget amounts with each hospital, in practice, the actual amount received by the hospitals may be much less, depending on the cash flow situation at the ministry. Also, the budget amount does not include salaries and wages or drugs and pharmaceuticals. The cash budget system that was

¹ US\$ 1.00 = MK 49.07.

introduced in 1995 makes funding of the hospitals a very uncertain proposition. This complicates planning, as hospital management is never certain of the actual budget allocated at any given month.

3.1.2. Organizational Structure

The organizational structure at both hospitals is very similar and follows the structure recommended by MOHP. It is not based necessarily on the structure that best suits the hospitals' needs as much as it is on a formation that is used throughout the MOHP hospitals. In reality, however, the reporting structure may vary depending on the management style of the hospital director and the capabilities of those reporting to him. For example, in Queen Elizabeth, the chief of the accounting department reports directly to the hospital director, while in Lilongwe, he reports to the chief administrator.

According to the formal organizational structure, the hospital director, who used to be called the Medical Superintendent, is the person ultimately responsible for the overall administrative, financial, and clinical performance of the hospital. The director typically has a chief administrator², chief matron, and, until recently, a medical superintendent reporting directly to him or her. Since the medical superintendent position was recently eliminated, the hospital director, who is also a physician, has the overall responsibility for the medical staff. The chief administrator is responsible for the day-to-day administrative and financial functions, including accounting, physical maintenance, and human resources. The medical equipment maintenance department, while located at the central hospitals, is outside the formal organizational structure of the hospital since it is responsible for serving all the other district hospitals and health centers in that region. The chief matron has overall responsibility for all nursing functions, including assigning nurses among the different wards, overseeing patient admissions, and managing shifts.

The third layer of hospital administrative personnel is divided by function and occupied by lower grade clerks who were not necessarily trained for these positions. They are technically considered the experts in their functions and report to the chief administrator.

3.1.3. Utilization

Although the National Health Service has a referral system through which those seeking health care are directed to the primary care sector, more often than not, patients directly seek central hospitals for their care. This has put pressure on the hospitals and stretched their limited resources. As a result, central hospitals suffer from a very high utilization rate that has taken a toll on already limited human and financial resources. The inpatient occupancy rate ranges from 120 to 150 percent depending on the time of year. These rates are derived from the daily patient logs kept at the various wards in the hospital. This high utilization rate is even more prevalent at the outpatient departments. Lilongwe and Queen Elizabeth Central hospitals estimate that approximately 70 to 90 percent of all outpatient visits are for routine primary care services that could have been treated at a primary health center or lower level hospital. Four reasons were mentioned as contributing to these high utilization rates:

1. There is limited capacity at the primary health centers and rural and district hospitals to absorb and treat large numbers of patients. Primary health centers and rural and district hospitals are generally understaffed and undersupplied.

² Queen Elizabeth Central Hospital has two administrators reporting to the hospital director.

2. The public has a general perception that the central hospital provides better care than a health center or lower level hospital.
3. Central hospitals are the primary referral centers for the entire country, and many of their patients travel considerable distances for treatment of what is, in many instances, a fairly routine condition that could have been treated at a health center or rural hospital. The treating clinician at the hospital's outpatient clinic often feels obligated to admit the patient to the inpatient wards rather than deny the person and have him or her undertake a long return trip home.
4. Finally, many outpatients require observation for only a few hours, but since there is no designated facility for "same-day treatments," these patients get admitted to the central hospital's inpatient wards.

Coupled with shortages in staff and resources, overuse of the central hospitals has caused the already limited resources to be stretched thin and has been blamed as the main constraint towards extending health care accessibility to the majority of the population. This has negatively impacted the quality of patient care offered particularly in the following:

- > Inpatient wards are overcrowded, with patients who sleep on the floor accounting for almost one-third of the total patient population at times.
- > Patients frequently wait for hours outside the outpatient clinics to see a provider.
- > The amount of time spent with clinicians has been steadily reduced in order to accommodate all patients.
- > The drug supply is usually running very short, and the medical equipment frequently is out of order.

Because of these reasons, primary health care provided at central hospitals has become a very costly undertaking for the government.

3.1.4. Staffing

Although they are considered to be among the better staffed and equipped facilities in Malawi, central hospitals are critically understaffed and undersupplied for facilities of their size and purpose. The shortage in staff is particularly visible among medical and nursing staff ranks (*see Table 1*). This shortage is not only evident in the number of positions left unfilled, but also perhaps more importantly in the quality of the staff already employed at both facilities. This problem encompasses all functions within the two hospitals' administrative, clinical, and support services. *Table 1* demonstrates the various hospital staff numbers by facility and position type.

Table 1. Number of Staff at MOHP by Facility Type and Personnel Category

Staff Category	Health Centers	Rural Hospitals	District Hospitals	Central Hospitals	Total
Specialists	-	0	0	18	18
Medical Officers	-	0	20	45	65
Dentists	-	0	0	2	2
Clinical Officers	-	12	126	79	217
Registered Nurses*	-	13	151	126	290
Enrolled Nurse*	450	80	381	264	1175
Public Health Nurses	-	0	19	0	19
Enrolled Community Nurses*	124	8	67	16	215
Environmental Health Officer	23	9	47	2	81
Health Assistants	152	13	84	0	249
Lab Technicians	-	0	8	14	22
Lab Assistants	-	2	33	38	73
Pharmacists	-	0	0	3	3
Pharmacy Technicians	-	0	3	5	8
Pharmacy Assistants	-	3	17	32	52
Physiotherapy Assistants	-	0	0	1	1
Radiographers	-	0	0	7	7
Radio Technicians	-	-	1	5	6
Radio Assistants	-	-	7	12	19
Dental Technicians	-	-	-	13	13
Dental Assistants	-	1	-	36	37
Medical Assistants	236	30	129	47	442
Health Surveillance Assistants	2,627	310	494	0	3,431
Total	3,612	481	1,587	1,134	6,800

Source Ministry of Health and Population 1997

* Nursing numbers were modified to reflect actual figures from Queen Elizabeth Central and Lilongwe Central hospitals at the time of the assessment.

Clinically, central hospitals employ the entire medical specialist force within the MOHP in addition to general doctors. Approximately 20 medical specialists practice at Lilongwe and Queen Elizabeth Central hospitals, and the majority of them are foreigners who are paid through external funding. In addition to the full-time specialists employed by MOHP, there are 21 part-time specialists based at the College of Medicine in Blantyre, who contribute significantly to patient care at Queen Elizabeth. These part-time specialists were initially envisioned to apply only 30 percent of their time to direct patient care, with the remaining time dedicated to teaching and research. However, due to the shortage of specialists at MOHP, these faculty members are spending almost 70 percent of their time in direct patient care.

In addition to the specialists, an estimated 53 general practitioners staff Lilongwe and Queen Elizabeth Central hospitals. Not all of these practitioners, however, provide direct patient care, and only about one-third of them are fully trained physicians who have finished their internship requirements (see Table 2).

Table 2. Physicians by Title or Rank Category

Hospital	Specialist	Medical Officer	Registrar	Interns	Other Training	Project Staff	Total
QECH*	17	3	1	12	4	1	38
LCH	14	3	0	8	8	0	33
Total	31	6	1	20	12	1	71

Source: Ministry of Health and Population 1999

Note: QECH—Queen Elizabeth Central Hospital, LCH—Lilongwe Central Hospital

* The Medical College in Blantyre employs 13 of the specialists who practice at QECH.

Considering the size of the population of Malawi and the fact that these two hospitals are the primary referral facilities for the entire country, the number of physicians is extremely low and indicates that health care delivery has to rely heavily on other categories of health professionals, such as clinical officers and nurses, for direct patient care delivery.

Clinical officers are health care providers that have been locally trained over a three-year period to diagnose and treat common medical and surgical conditions including selected operative procedures. Conceptually, they should be working under the direct supervision of a physician, but in practice this does not happen because of the shortage of physicians. Clinical officers provide a wide range of direct patient care and are considered a major part of care delivery at the central hospitals in particular and the health care system in general.

In addition to physicians and clinical officers, nurses are by far the largest providers of direct patient care at the central hospitals; however, they also suffer from shortages in their ranks. An estimated 512 nurses staff Queen Elizabeth and Lilongwe Central hospitals. Of those, approximately 126 are registered nurses and the remaining majority are enrolled nurses. Registered nurses are trained over a three-year period at the end of which they are qualified to practice. The tradition has been, however, that they proceed to undertake a one-year post qualification program in midwifery. Enrolled nurses are trained over a two-year period, and the majority of them have also completed a one-year midwifery post qualification program. Other types of nurses who work at the central hospitals are psychiatric and ophthalmic nurses.

3.1.5. Planning and Performance Monitoring

In this context, planning means the hospital's ability to draw up long-term strategic plans and short-term implementation plans. The assessment revealed that the central hospitals do not do much of any kind of planning at any level. The senior staff team, which is responsible for planning and monitoring, does not meet on a regular basis to plan, review, or receive updates regarding hospital progress. In fact, the department directors do not require staff to submit weekly or monthly status reports that highlight key indicators of the hospital's performance.

Planning and performance monitoring are sporadic activities. A few department heads monitor the performance of their own departments even though there are no requirements to collect and monitor performance indicators. Information or findings that are obtained are not typically shared with other senior management who may find them useful.

By definition, the planning function is the responsibility of the hospital director and his senior managers, yet, for a number of reasons, it is hardly carried out in a systematic organized fashion. One reason is that hospital directors are trained physicians who did not receive any formal training in hospital administration and, in some cases, their tenure at the central hospital is their first experience with

managing a hospital. Therefore, they do not perceive planning as an important task that requires their time. Another reason is the magnitude of the problems hospitals face and their directors' beliefs that they have no control over solving these problems because of their lack of decision-making powers.

3.2. Financial Management

3.2.1. Organization and Staffing

The Senior Management Services staff of the Department of Human Resources Management and Development (DHRMD) has stated that the government accounting system (guided by existing financial instructions) is basically “straightforward” and that generally there may be no need for professionally qualified accountants at any level in the system. The introduction of the cash budget system is thought to have applied a level of control and fiscal discipline that simplifies the financial planning task at the operational level and further “de-skills” the accounting function. In marked contrast, the situation at the central hospitals regarding accounting is far from satisfactory. This is partially due to changing to a new classification system for which the hospitals had few advance guidelines or sufficient personnel training. In addition, there is an insufficient number of qualified personnel who can provide adequate supervision even for the basic government system.

The PHR team conducting the assessment at the two central hospitals found that internal control systems are typically incomplete and records are not well constituted or maintained. No routine internal audit reports were available. Financial information reports were mainly restricted to the routine returns of expenditure and revenue in compliance with financial instructions; otherwise, no internal financial management reports exist.

In the case of Lilongwe, team members were not able to accurately assess the financial position of the hospital at the time of their visit because of incomplete records. Queen Elizabeth Central was in the process of rewriting the books of account to convert to the new classification system. The hospital does produce a basic budgetary control statement using a computer spreadsheet; otherwise, information technology resources are few and are not effectively used.

Neither hospital has financial reports designed to meet the specific needs of individual managers or to provide performance measurement. There are no costing systems in place, and the hospitals have almost no capacity to implement any management accounting systems that can act as a link between the strategic decisions and the operational decisions. It is necessary to have a mean/ends relationship between the two levels of decision; otherwise the hospitals have no effective way of achieving their strategic objectives.

Lilongwe has established a position for a principal accountant; however, the department is headed by a senior assistant accountant who has received training at the Staff Development Institute. This is currently the most senior-filled position. The planned number of posts and the actual number of filled positions are shown in *Table 3*.

Table 3. Lilongwe Central Hospital Accounts Department–Staff Establishment 1999–2000

Post Title	Plan	Filled
Principal Accountant	1	0
Assistant Accountant	2	1
Senior Accounts Assistant	2	2
Accounts Assistant	10	5
Ward Clerks	20	5
Total	35	13

The basic salary of an assistant accountant is approximately MK 40,000/annum, which is equivalent to US\$17.50/week. The total 1999–2000 budget for Lilongwe exceeds US\$2.5 million.

At Queen Elizabeth, a principal accountant who has been in post since July 1999 manages the department. (Formal training is limited to the foundation stage in professional accounting, and the incumbent has worked in this service for 18 years.) The department is divided into two main sections, revenue and expenditure, and there are two assistant accountants, one for each section. Accounts assistants (clerical officers) are also assigned to each section.

3.2.2. Financial Management Training and Staff Deployment

Computer data processing training coupled with continuing professional development of staff could meet the needs of the central hospitals in the longer term. Technical assistance is required, however, as a stopgap measure to act as an agency for change and to assist with on-the-job training.

The Treasury could provide other training through its data processing departments, government scholarship funds, and local training organizations, such as the Malawi College of Accountancy, the Polytechnic, and Malawi Institute of Management.

The question of reassigning existing staff has been raised in discussions with the DHRMD. If existing hospital staff do not have the right mix of skills and experience and cannot be expected to acquire these through short-term training, then some form of search does need to be carried out to identify the most suitable staff for the key management positions in the hospitals. Under the present civil service regulations it would clearly not be possible to “compete” for positions that are already filled, and in the more senior posts, there may be few opportunities for transfer at the same level.

3.2.3. The Budget System and the Medium-Term Expenditure Framework

At the time of the assessment, the hospitals were changing their accounting codes or line item codes to adjust to the uniform classification scheme used under the Medium-Term Expenditure Framework (MTEF). MOHP was one of the initial four ministries in the Malawi Government involved in the MTEF exercise, which started in 1995–1996 as part of the International Monetary Fund structural adjustment program (now extended for all line ministries). In FY1996–1997 MOHP conducted logframe exercises, developed sectoral objectives, and initiated the move away from incremental budgeting towards a more programmatic approach.

The MTEF is intended as a management tool to improve the allocation of resources between and within sectors and to improve macroeconomic balance by developing consistent and realistic estimates of

available resources. It was also envisioned as a tool to restructure and rationalize allocation of resources so that priority activities receive adequate funding, to move away from the incremental approach to the preparation of the recurrent budget to actual costs of services, and to integrate the recurrent budget with the development budget (Nkosi 1998). How successful this process has been in the case of MOHP, and the extent to which the MTEF has introduced improvements to the former budgeting system by integrating the recurrent and investment program budgets, requires further study.

This integration process should have improved the balance of the budget by avoiding unsustainable revenue expenditures driven by capital investment, new infrastructure, and development programs.

The ministry developed new program budget classifications in 1996–1997 that should have made it easier to see program priorities and should have driven a process of program prioritization, including program elimination. The old accounting code structures essentially reflected the accounting inputs (i.e., nominal expense accounts or line items) and were to give way to new classifications based on “programs.” However, it is difficult to see how these changes can be described as contributing to a results-oriented approach, or can provide for any output or performance measures, and how they can rationalize the allocation of resources.

The 1999–2000 budgets for the two central hospitals indicate that analysis of expenditure is done at very aggregate levels. The entire nonpay costs and other recurrent charges for the hospitals are broken down into seven line items or nominal expense codes with one further code for the formation and maintenance of assets. This is completely inadequate for internal control and decision making, especially taking into account that the entire budget program structure is largely unworkable because it fails to deal with joint costs. In addition, neither hospital has a costing system in place. For example, the only staff costs shown under Outpatient Services in the case of Lilongwe Central Hospital are actually for the Dental Unit alone. For convenience, the total cost of utilities (water, light, and power) and all rents are shown under Hospital Services Management, which grossly overstates the administration costs.

The hospitals urgently need to develop an appropriate chart of accounts that will adequately handle their adjustment to more businesslike operations and that will establish the framework for changing to an accrual basis of accounting. From discussions with the chief accountant at MOHP, the need for this change may not be fully incorporated into the proposed Integrated Financial Management System that is to be implemented by all units to automate the production of the standardized financial returns of the cash accounting system.

The business modules of the accounting systems required for effective financial management of the hospitals include sales invoicing, inventory control, and purchase order processing, as well as fixed assets accounting and systems for cost accounting. These should integrate with the main general ledger accounting side of running the hospitals (as well as the patient administration system), and most state-of-the-art, off-the-shelf software should be able to produce reports that would fit the Treasury’s reporting requirements.

Management needs to focus on the fact that costs are primarily incurred as a result of decisions and actions taken by hospital staff. To control activities effectively, it is essential to identify the individuals who have the responsibility for the activity. Effective control requires a clear and well-defined organizational structure, and both hospitals need to urgently review all the functional areas that are poorly organized and poorly supervised and begin to develop and manage an organizational structure that provides for effective control. This involves establishing standards at all levels and implementing a hospitalwide program of quality improvement.

There has been a limited attempt to prepare departmental “estimates,” but the budget process is not effective in making and coordinating plans, or in communicating those plans to those responsible for carrying them out. No one is using the budget to motivate managers at any level in the organization, and the budget is not being exploited as a means of setting standards against which the performance of managers and departments can be measured.

3.2.4. Hospital Workload

Some statistics relating to the overall workload of the hospitals are maintained, but the system is very patchy and the information is largely compiled for reporting to MOHP rather than for internal management and control. *Tables 4 and 5* summarize the current workload at both hospitals.

Table 4. Lilongwe Central Hospital Inpatient Workload

		Avg. Daily Bed_Occ	Avg. Monthly Bed_Occ	% of Total Bed_Occ	Avg. Monthly Admits.	Avg. Length of Stay
Male Surgical	1A	95	2,850	9.1	240	11.9
Male Surgical	1B	65	1,950	6.3	90	21.7
Female Medical	2A	33	990	3.2	180	5.5
Male Medical	2B	33	990	3.2	180	5.5
Eye	Eye	200	6,000	19.2	270	22.2
Gynecology	3A	70	2,100	6.7	180	11.7
Maternity (Fee Paying)	3B	20	600	1.9	85	7.1
Female Surgery	4A	36	1,080	3.5	90	12.0
General (Fee Paying)	4B	12	360	1.2	60	6.0
Pediatric		140	4,200	13.5	900	4.7
ICU		5	150	0.5	30	5.0
OLD WING (all maternity wards)		200	6,000	19.2	830	7.2
TB		75	2,250	7.2		
Psyche		40	1,200	3.8		
MAP/Rehab (Polio)		15	450	1.4		
Subtotal		130	3,900	12.5	155	25.2
TOTAL		1,039	31,170	100.0	3,290	9.5
Average Monthly OPD Visits			16,153			
Equivalent Inpatient Days	10%	PDE	1,615			
Total Inpatient Days	monthly		32,785			
Total Admissions (Cases)	monthly		3,460			

Patient Day Equivalents (PDEs) are calculated at 10 percent. This means that 10 outpatient department (OPD) attendance are treated as equivalent to one inpatient day for costing purposes. This is illustrative only—the actual contribution to total costs (clinical staff, nursing staff, support services, and supplies and overhead) may be higher. Note that with the present mix of inpatient and outpatient services the overall average cost per day is not very sensitive to the PDE figure used. For example, if the PDE is calculated at 20 percent (five OPD attendance is equivalent to one inpatient day), then the average cost per day will decrease by only 5 percent.

Table 5. Queen Elizabeth Central Hospital Inpatient Workload

		Avg. Daily Bed_Occ	Avg. Monthly Bed_Occ	% of Total Bed_Occ	Avg. Monthly Admits	Avg. Length Of Stay
Pediatric		172	5,160	19.0	1,200	4.3
Maternity (Paying)	2A	18	540	2.0	Incl. in total maternity	
Medical & Surgical (Paying)	2B	20	600	2.2	60	10.0
TB Wards Male & Female	3A	133	3,990	14.7	60	66.5
Male Medical	3B	65	1,950	7.2	480	4.1
Female Medical	4A	49	1,470	5.4	660	2.2
Total Eye Wards	4B	33	990	3.6		—
Male Surgical	5A	53	1,590	5.8	195	8.2
Female Surgical	5B	67	2,010	7.4	135	14.9
Orthopedic Male	6A	74	2,220	8.2	90	24.7
Leprosy, Skin Cond.		10	300	1.1		—
ICU		2	60	0.2		—
Burns Unit		21	630	2.3	60	10.5
Subtotal		717	21,510	79.1	270	79.7
(Chatinka) All Maternity		189	5,670	20.9	1,695	3.3
TOTAL		906	27,180	100.0	1,965	13.8
Average Monthly OPD Visits			15,400			
Equivalent Inpatient Days	10%	PDE	1,540			
Total Inpatient Days	monthly		28,720			
Total Admissions (Cases)	monthly		2,076			

The admissions and discharge data for Queen Elizabeth Central Hospital were based on the most recent utilization and census figures as a time series was not available and no complete historic record is maintained in an accessible form. Figures for the average length of stay are therefore approximate for Queen Elizabeth, but they are still clearly much too high. Lilongwe has an average length of stay of 9.5 days with maternity close to this average. Clearly, treatment procedures need to be reviewed for almost all specialties, and systems need to be installed that ensure clinical guidelines are followed and hospital formularies adhered to.

3.2.5. Cost Structure

As mentioned earlier, analysis by subprogram is not meaningful because it fails to deal with joint or common costs. *Table 6* shows the estimated costs based at Lilongwe on a PDE of 10 percent.

Table 6. Lilongwe Central Hospital 1999–2000 Cost Structure

Description	Budget 1999-2000	% of Total	Estimated Cost/Day*	Cost/ Case**
Personal emoluments	33,046,370	29	84	796
Drugs & medical/surgical supplies	42,500,000	38	108	1,024
Internal travel	3,885,333	3	10	94
Public utilities	8,812,288	8	22	212
Office supplies	7,124,666	6	18	172
Rent expenses	421,716	0	1	10
Training	1,021,620	1	3	25
Food and ration	14,697,477	13	37	354
Other goods & services	700,840	1	2	17
Maintenance	921,289	1	2	22
Subtotal Other Recurrent Transactions	37,585,229	33	96	905
Total	113,131,599	100	288	2,725

* Bed occupancy: 393,420

** Cases: 41,520

Total fixed costs are approximately 40 percent of the total costs, which is a fairly low percentage compared with many other tertiary hospitals in the region (this is a function of the relatively low levels of pay in Malawi). Increases in pay coupled with a reduction in bed occupancy and average length of stay are likely to significantly increase the average cost per day. As many costs are case specific (e.g., drugs and surgical supplies, laboratory, operating theatre), a substantial reduction in average length of stay will not significantly reduce total costs. If the total number of cases treated remains at the present level, then a reduction in average length of stay from 9.5 days to 7 days could reduce bed occupancy by a corresponding 25 percent. Savings will be realized on the total food bill and other hotel services and some supporting staff could be reduced, but average costs per day will still increase significantly and could reach MK 390/day.

The Hospital Autonomy Working Group's report of July 1997 suggested that the hospitals' system of resource allocation (and performance monitoring) could be based on the concept of a negotiated contract for services between the MOHP as purchaser and the hospital as provider. This requires a full understanding of the cost structure of the hospital, including average costs and marginal costs as well as cost-volume relationships, and the effect of case mix on weighted average costs. Initial contracts could be based on overall hospital-level costs using average figures that are calculated with an agreed PDE and would provide a basis for determining the block grants and the level of government subsidy.

3.3. Human Resources Management

3.3.1. General

The human resources (HR) function is fragmented among various entities within and outside MOHP. Each entity is responsible for a specific function depending on the nature of that action and the

grade of the position requiring that action. In general, the hospitals play a fairly small role in initiating and implementing HR functions. Compounding the problem is the fact that a fairly low-level clerk is responsible for HR at the hospitals, and this person was not trained to manage all the different HR functions at such a large institution. The personnel function within the hospital reports directly to the chief hospital administrator; however, much of this function is coordinated with the Public Service Commission (PSC), the DHRMD, the Treasury Department, and the MOHP itself. Each of these entities was created to play a specific role within the overall function of HR.

As a general rule, recruitment, promotion, disciplinary actions, and dismissal are the responsibility of the PSC. The DHRMD is responsible for creating, regrading, and reviewing all public service positions. The hospitals are merely the recipient of these services.

3.3.2. Creating New Positions

The function of creating new positions is divided into two distinct activities: creating the position and filling that position. Generally, DHRMD is responsible for creating a new position. This is typically based on a request from the hospital or the identification of a need for that position at MOHP. The hospitals have some discretion over creating lower grade positions (i.e., industrial and subordinate class), assuming these positions were identified in the budget.

To create higher grade positions, such as a technical assistant or clinical officer to the senior technical assistant or senior technical officer, the DHRMD, through its Appointment and Disciplinary Committee within MOHP, first seeks approval from the Treasury regarding funding. For industrial and subordinate class grades, the hospitals can fill these positions immediately assuming availability of funds in the budget. For senior grades, such as executive officer or technical officer to the chief technical officer, the PSC is responsible for securing funding from the Treasury.

Although the hospital theoretically has the authority to create and fill a position in the industrial and subordinate grades, in reality, that will not happen unless there is prior approval from the central MOHP. This in essence defeats the purpose of giving hospitals this authority in the first place.

3.3.3. Recruitment

The steps taken to fill new or vacant positions differ depending on the grade level. The authority to recruit and employ industrial and subordinate class vacancies was decentralized. For these grades, the hospital can conduct its own interview process and hire directly, although only a few of the senior managers in fact realize that they have this authority. As for the mid-level grades, the MOHP Appointment and Disciplinary Committee, through delegated powers from the PSC, can interview and hire candidates and then notify the hospital as to whom they hired. For senior-level positions, recruitment is conducted directly by the PSC, which notifies the hospital once a candidate is hired.

Filling vacancies for mid- and senior-level positions is generally considered a problem at central hospitals because of the lack of financial resources and qualified candidates, and the cumbersome hiring process. Under all hiring scenarios, the hospitals do not participate in the recruitment process for mid- and senior-level grades. In summary, issues of staff development are coordinated centrally by the Ministry. Central hospitals have no control or input in staff recruitment, development or posting.

3.3.4. Promotion and Dismissal

As a general rule, promotions and disciplinary actions are the responsibility of the PSC. At the hospital level, promotions are possible only when a position at a higher grade is vacated. Although there are other avenues for advancement, they are rarely used and most staff is unaware that they exist. For example, an individual can advance to a higher grade if he or she has been in the same grade for eight years and has an outstanding performance record. Advancement is also possible within grades when individuals receive additional training at the degree level.

Hospitals have the authority to recruit and hire industrial and subordinate class personnel. They also have the authority to dismiss only industrial class employees. Supervisors can complain to the chief administrator or director about the performance of one of their staff, but that is all they can do. Only the PSC, or the Appointment and Disciplinary Committee, which enjoys delegated powers from the PSC, can make decisions concerning dismissal.

3.3.5. Performance Evaluation

Evaluation of staff performance is not a routine function within the central hospitals. In fact, performance evaluations are not required other than for professional staff, and even this is done sporadically. On the rare occasions when evaluations are conducted, the supervisor typically prepares the evaluation without any input from the subordinate. The evaluation, if conducted, is kept in the employee's confidential file in the chief administrator's office separate from the regular file kept at personnel. In practice, central hospital personnel say they receive little feedback from supervisors.

3.3.6. Staff Development and Training

Other than the practical training provided at the central hospitals for students from the nursing school and the Medical College, neither hospital has a formal staff development plan. Occasionally the hospitals may send an individual or group to training programs that are funded by a donor organization, but these types of programs are not implemented as part of a larger training plan that identifies staff training needs.

The PHR assessment determined that job performance is a major problem at central hospitals. As a result, training will be a major factor under any plan to implement hospital autonomy. The job performance problems were traced primarily to the following:

- > Staff members perform in jobs for which they were not trained.
- > There is a lack of adequate "on-the-job" training.
- > There is a lack of clear expectations and accountability, which leads to a sense of indifference.

The general perception from the assessment was that many of the existing administrative and financial staff might not be ready to actually assume more responsibilities under any scenario for increased hospital autonomy. Although the general idea of having more authority sounds appealing, if staff are not qualified and motivated, it will be considerably hard to reach the level of autonomy envisioned.

3.4. Procurement Management

The discussion in this section focuses on Lilongwe Central Hospital, as procurement information on Queen Elizabeth Central Hospital was not available for the assessment team's review.

3.4.1. Lilongwe Central's General Stores

Lilongwe Central's general stores are managed by a store supervisor who is assisted by three store clerks and one general laborer. The general stores are organized into purchasing, receipts, and warehouse management sections. There are three main categories: textiles, stationery, and hardware including cleaning materials.

Lilongwe Central had no overall purchasing plan for 1999–2000 or any systematic approach to gather price information for regular goods or other items. There appeared to be no routine reporting system. The stock control system does use re-order levels for some items.

The purchase limits said to be in force were those contained in the circular of September 16, 1996:

Central Tenders Board MK 2,500,000

Medical Buying Board MK 2,500,000

Government Central Stores (various) MK 500,000

Central Medical Stores MK 500,000

Various units MK 200,000

Other ministries/departments MK 100,000

Limits are per item per order. The hospitals are therefore operating at the lowest level with a purchase limit of approximately \$2,500 on any single item/order.

The store supervisor is presently not a member of the committee that approves purchases from the user fee account. (The committee is made up of medical doctors and heads of departments.)

3.4.2. Kitchen

Excluding drugs and medical and surgical supplies, food and ration is by far the largest item of expenditure in the other recurrent transactions (ORT) section of the budget, accounting for approximately 40 percent of the total. The Central Tenders Board awards contracts for supply of food.

Lilongwe Central maintains a stores ledger that records all receipts and issues to the kitchen and the daily stock balances of each item. Reporting and analysis are limited by manual recording, although some costing is conducted to calculate the average daily costs of feeding patients, both paying and nonpaying wards.

Although they consume fewer than 7.5 percent of the total number of meals served, paying patients account for approximately 35 percent of the total food bill. Average costs per day for paying patients was estimated at over MK 50 compared with ward fees of MK 300 for a single self-contained room per day. Average costs of feeding nonpaying patients are estimated at less than MK 10 per day with almost no variation in the daily menu. (Note that this figure is well below the budgeted figure for 1999–2000 with a provision exceeding MK 25 per day; therefore, the cost data is probably not reliable).

3.4.3. Pharmacy

Budgets for Drugs and Medical Supplies

At the hospital level, budgets for drugs and medical supplies are prepared by producing estimates of requirements based on previous use, which is determined by referring to individual item tally cards (bin cards). The tally cards, however, are not regularly summarized to give monthly totals of issues and receipts. Hospitals exercise rudimentary budgetary control over the purchase of drugs and medical supplies. Generally, they divide their annual monetary budget by 12 to serve as a guide for monthly purchases from the Central Medical Store (CMS). The assessment found no indication, however, that hospitals maintained control ledgers to reconcile CMS invoices or to control expenditures, yet drugs and medical supplies account for 40 percent of total hospital costs.

Budgets for drugs and medical supplies are prepared and “controlled” centrally by CMS and are not shown under the hospitals’ program/subprogram listings. By October 1999, the working budget held by CMS to monitor expenditure of Lilongwe Central Hospital was kept equal to that of 1998–1999, amounting to MK 25,784,000.

Lilongwe’s actual expenditure or costs of supplies, however, for 1998–1999 was MK 46,417,025, or 80 percent over budget. By the end of the first two months of the financial year, total expenditure amounted to more than MK 7.0m, so the hospital already had an adverse variance of 65 percent on the year-to-date budget.

This amount of overspending is approximately equal to the total ORT budget for 1999–2000 on all other votes combined, excluding food, and it seriously undermines the entire budgeting and budgetary control processes of MOHP.

A transfer of the budgets and cash back to the operating units is planned to take place once the CMS is reorganized and privatized. It should be noted that the present central “control” system was reportedly introduced to prevent abuse of the votes when funds were managed by the individual cost centers.

Order Processing

For inpatients, the pharmacy or dispensary generally employs a system of ward boxes for issuing supplies to the wards—two boxes are used for each ward. One box is used for oral tablets and injectables (issued against returned empty containers with order books being used for additional needs), and the second box is reserved for oral antibiotics (issued by case note/patient file to maintain control and reduce the opportunity for pilferage).

The outpatient department is usually issued tablets in bulk. The packing room maintains control over antibiotics and issues them in batches of 10 prescriptions. The packing room completes a daily order from the main store with variable order quantities each day, depending on which clinics are held.

The hospitals have no manual system of inventory control. They do not use stores registers or ledgers that can allow receipts and distributions to be recorded separately from the records entered on the tally cards. The CMS procedure only requires that some form of inventory record, such as the tally card, be kept to record supplies for orders placed with CMS. These records may be checked with Regional Medical Store records.

There is partial recording of distributions on subsidiary tally cards. For example, in the case of injectables, duplicate books are used for requisitioning surgical supplies along with record sheets that do use serial numbers. But these incomplete manual records cannot form the basis of an effective internal control system or provide a suitable audit trail. During the assessment, the pharmacy technician in charge indicated that the last attempted audit was conducted in December 1997 by staff from MOHP and the auditor general's office.

Shortages of medical supplies at CMS are due to the system of placing small orders more frequently, compared to the formal system that recommends that stock be ordered every three months. For example, between August 9 and 17, 1999, Lilongwe Central Hospital received 44 separate invoices from CMS for supplies. In practice, no working maximum or minimum inventory requirements of any sort exist based on consumption data or predictable lead times. Everything is ordered on an "emergency basis." How CMS coordinates the supplies is reportedly very weak, with stocks moving from minimal to overwhelming levels.

The 1999 CMS catalogue contains approximately 1,200 items, comprising 800 medical supply items (surgical, bandages, laboratory supplies, dental items) and 400 drug items falling in the essential or vital category. In contrast, at the time of the assessment, Lilongwe Central Hospital had fewer than 90 items (22.5 percent of the catalogue) in stock, with many items counted at below minimum stock levels or even close to nil levels. Based on this reality, the framework for the proposed support from the Department for International Development for CMS Reform Project (DFID 1998) sets targets or indicators for items in stock at 100 percent for vital and 80 percent for essential drugs in all hospitals and health centers at all times.

An analysis of Lilongwe Central Hospital's drug purchases during August 1999 (the only month available) indicated that the purchases amounted to MK 4.7m, or approximately 20 percent of the approved annual budget. Invoices were analyzed and the information is summarized in *Table 7*.

Table 7. Analysis of Drug Purchases at Lilongwe Central Hospital

Description	Expenditure	% of Total
Tablets/capsules	745,580	16
Injectables	431,822	9
Vaccines	0	0
Raw materials	0	0
Galenicals (ear, eye, topical, oral preps)	131,817	3
Surgical dressings	742,967	16
Sutures	801,285	17
Surgical items	1,269,864	27
Specs	0	0
Dispensary items	0	0
Hospital equipment	0	0
Laboratory items & materials	159,057	3
X-ray items & materials	418,294	9
Dental items	0	0
Miscellaneous items	0	0
TOTAL	4,700,686	100

Reports indicating the stock balance, used primarily by medical doctors, are produced every two weeks. There are no routine reports that show inventory or inventory analysis by user or ward, slow-moving items, or any information that would support costing.

4. Conclusion

The problems at Queen Elizabeth Central and Lilongwe Central hospitals are well known and documented in many other studies. Moreover, many hospital functions such as human resources have already been thoroughly studied. This assessment did not expect to reveal anything new regarding hospital procedures nor did it analyze the details of how these hospitals are conducting their operations. Rather, the assessment focused on assessing the ability of the central hospitals to improve efficiency and implement autonomy if they were requested to do so.

The assessment's primary objective was to help devise an implementation plan whereby the two hospitals could become autonomous. In order for the plan to be practical and doable, the assessment had to consider both the internal and external operations of the hospitals. Based on the assessment, the following are the main points that will have to be addressed in drafting the implementation plan:

- > Queen Elizabeth Central and Lilongwe Central hospitals will continue to rely, at least to some extent, on financial support from the government.
- > The existing referral system must be changed to ease some of the pressure off the hospitals' limited resources stemming from overutilization.
- > Changes in the central hospital operations will have to be made in conjunction with a plan to improve the overall care within the health centers and rural and district hospitals.
- > A new, dependable stream of revenue must be developed to supplement the government subsidy.
- > Unless the skills of existing personnel are enhanced, any improvements are likely to be hampered.
- > For the hospitals to reach any level of autonomy, they must establish policies and procedures that will facilitate reporting and accountability.
- > Finally, and perhaps most importantly, any realistic plan will have to build the necessary political commitment to implement changes.

4.1. Decreasing Government Financial Support

It was clear from the outset of the assessment that the purpose of providing central hospitals with autonomy is essential to improve their efficiency and assist them in becoming less financially dependent on government support. However, these hospitals principally treat an indigent population that requires subsidized care, and they will continue to do so in the foreseeable future. As a result, introducing operational autonomy, even if it includes some form of cost sharing or user fees, will not likely translate into a reduction in the amount of financial support central hospitals require from the government. Implementing autonomy can, however, stabilize the amount of government financial support and ensure that it does not continue to increase.

4.2. Establishing a Referral System

The assessment found that the two central hospitals spend too much of their limited financial and human resources on providing primary- and secondary-level care. This type of care should be provided at health centers and rural or district hospitals. Without a strict referral system that can implement guidelines for referrals to the central hospitals, many of the efforts expended to improve efficiency will be wasted. Since the central hospitals have no jurisdiction over other MOHP facilities, the MOHP should impose a referral system and include some form of utilization management mechanism to review referral patterns and make necessary changes.

4.3. Strengthening the Primary Care System

Lilongwe and Queen Elizabeth Central hospitals are the two principal tertiary centers for the entire country. Because of their size, teaching mission, number of specialists, and amount of resources that flow into them, the hospitals are considered the centerpiece of the health care system in Malawi. This designation has both helped and harmed the central hospitals. They get all the specialists, advanced medical equipment, and generally the attention of the MOHP, while other facilities in Malawi's public health system are suffering from extreme shortages of specialists, equipment, drugs, and qualified staff. This in turn creates more demand for the central hospitals to provide primary care services that ideally should be provided elsewhere. This demand is partially justifiable, but also partially based on the perception that non-central hospital facilities cannot provide as good care as the central hospitals.

Since Lilongwe and Queen Elizabeth hospitals' success in achieving their missions is closely dependent on the success of other non-tertiary facilities, it is essential that any plan for implementing autonomy should take into consideration strengthening the primary and secondary care systems as well.

4.4. Developing New Sources of Revenue

Health care facilities in general are currently faced with a dilemma: they are almost entirely dependent on insufficient government support, and at the same time current laws do not allow them to charge for their services so they can recover some of their costs and meet much needed operational expenses. As a direct result, the quality of care has deteriorated significantly and these health care facilities are ultimately failing to meet the objective of their existence, whether at the primary, secondary, or tertiary level.

Revenue is perhaps the most complicated issue when dealing with implementation of hospital autonomy. The government has obligated itself to providing free or affordable health care to an obviously poor population. Even if it allowed hospitals to introduce some form of user fees, this may discourage the targeted users from the facilities that were created to serve them in the first place. To learn how to overcome this problem, a careful study is needed of what fees can realistically be applied while ensuring that other options exist for those who may not be able to afford the fees.

4.5. Enhancing Personnel Skills

The initial assessment of the two central hospitals indicated that there are gaps between the skills and qualifications of some staff and the requirements of their current positions. This is particularly true among the various administrative and financial personnel, where the assessment was focused. Since it will

ultimately be the responsibility of those staff members to implement autonomy by taking on additional responsibilities, it is important to examine ways to raise their skill levels. There are two methods to do this: one is to train or retrain staff to learn new skills and acquire new techniques; the other is to reorganize some of the existing positions at the central hospitals and switch staff who may not be needed with staff from other MOHP units who may fit the profile. The latter method will require the MOHP's approval and possibly approval from the DHRMD or PSC. It would be used mainly to circumvent existing laws that do not allow the hospitals to make staff decisions.

4.6. Establishing Hospital Management Systems

Hospital management systems are what hold the various components of a hospital together and make it function in a uniformed collective manner. These systems consist of the policies and procedures that control interdepartmental relationships and facilitate all reporting requirements. Without them, it is impractical to expect a hospital to be efficient. The assessment of Lilongwe and Queen Elizabeth Central hospitals revealed that hardly any organized method for running the hospitals or their departments exists. The hospitals rarely follow any planned policies and procedures in their administrative or financial operations. This is not to say that there are no methods for doing the various tasks, but rather that whatever these methods may be, they are more likely to be an offhand reaction to a specific situation or a habit that is done without giving much thought to its effectiveness.

Most of the efforts made to introduce some form of organized procedure or structure were based on individual efforts and typically have no value except to the individual who initiated them. For example, because no financial reporting requirements exist to track monthly revenue generated from paying patients, a department director may have created a system for his or her own department. Such systems exist without the knowledge of others, and therefore a multitude of systems could have been created within the same organization.

Establishing effective management systems is not something that can be done within a few weeks or even months, but it is necessary that they be installed and working by the time the central hospitals are ready to increase their level of operational autonomy.

5. Recommendations

To achieve hospital autonomy in Malawi, an implementation plan should focus on decentralizing the decision making to the central hospitals with regards to five main administrative and financial functions:

- > Strategic management,
- > Procurement,
- > Financial management,
- > Human resources management, and
- > Administration.

To increase the likelihood of success, given the bureaucratic limitations within MOHP and the sensitivity of the hospital autonomy issue, an independent high-level “executive implementation committee,” separate from MOHP, should be created to take full responsibility of all implementation activities of hospital autonomy. Since MOHP has a direct interest in these hospitals, the “implementation committee” should be directly responsible to the cabinet’s higher committee on health care.

Based on the assessment findings, the team recommends a three-phased implementation plan that attempts to address existing and potential obstacles that could pose a problem for the realization of hospital autonomy (see *Annex A*). Since this is not an activity that can be implemented within a year or two, hospital autonomy is presumed to be a long-term commitment for the government of Malawi in its quest to improve the quality and accessibility of the health care delivery system.

The proposed three-phased plan emphasizes the progressive nature of implementing hospital autonomy. Most importantly, the plan emphasizes the importance of developing a strong infrastructure that can increase the likelihood of success.

- > **Phase I** – focuses primarily on alleviating some of the existing pressure placed on the hospitals caused by overuse and initiates the efforts to strengthen the operational and organizational structure at the two central hospitals.

During this phase, much of the effort will be focused on strengthening the primary care delivery system and motivating primary care patients to seek treatment at these facilities through various mechanisms such as implementing a specialists rotation system, developing referral guidelines that would be directly tied to a utilization management program to monitor compliance, and expanding the user fee concept.

Also during this phase, there will be some effort to determine the specific weak personnel and operational areas at the hospitals that will require reinforcement and build up.

Finally, the task of creating and building the necessary political support and commitment will commence during this phase. This will be an ongoing activity throughout the three phases of implementation to ensure mobilization of the necessary support.

- > **Phase II** – concentrates on training efforts and the implementation of necessary hospital management systems.
- > **Phase III** – concentrates on completing and implementing changes in laws and regulations that concede more autonomy to the hospitals.

Implementing hospital autonomy will most likely require a Public Organization Act by the Parliament that defines the legal characteristics of the autonomous hospitals such as the following:

- > The hospitals’ relationship with MOHP.
- > Financing of the hospitals through vertical block grants and/or transfers from MOHP and locally generated revenue with clear and transparent lines of authority both within the hospital and between the hospital and the MOHP.
- > Retaining locally generated revenues with full responsibility for all hospital resources. Maintain transparent accounting of all resources regardless of source.
- > Establishing of “executive limitations,” which set the guidelines for the hospital director’s responsibilities and authority.

Annex A. Implementation Plan

Malawi

Ministry of Health and Population

**HOSPITAL AUTONOMY STUDY:
PLANNING FOR IMPLEMENTATION**

Partnerships for Health Reform

September 2000

Contents

C	Overview of Hospital Autonomy	
-	Defining Hospital Autonomy	1
-	Extent of Autonomy.....	1
-	Objectives of Implementing Autonomy in Malawi	2
C	Strategy	
-	Overview	3
-	Changing Outside Determinants of Autonomy	4
-	Integration of Implementation	5
C	Implementation	
-	Phase I	8
-	Phase II	14
-	Phase III	17
C	Communications	19
C	Timeline for Key Steps	21

OVERVIEW OF HOSPITAL AUTONOMY

Defining Hospital Autonomy

The concept of hospital autonomy has originated primarily in countries where central health authorities had primary responsibility for the provision of curative inpatient care in addition to their traditional tasks of planning and regulating health programs. As the cost of inpatient care rapidly increases, the role of governments in providing these services is being seriously revisited. There is wide consensus that hospital autonomy is the direction to go if there is commitment to improve efficiency and quality in publicly owned hospitals.

Hospital autonomy is defined as the course of action taken when central government health authorities engage in the process of transferring operational powers to government owned and operated hospitals with the purpose of improving efficiency and quality of care.

Extent of Autonomy

The extent of autonomy and how it impacts the government's role in financing and providing inpatient care is often left to individual countries to decide based on their specific needs and circumstances (see Figure 1). In all, this has led to a wide variation in implementing hospital autonomy among countries depending primarily on what they want to achieve and the time-period in which they want to achieve it.

Figure 1 – Levels of hospital autonomy



OVERVIEW OF HOSPITAL AUTONOMY

The extent of implementing hospital autonomy can vary from practically privatizing public hospitals, to the mere decentralization of certain management functions. In all cases, the decision to reform public hospitals, as far as giving hospitals more autonomy over their daily operations and regardless of the level of that autonomy, has traditionally been defined as hospital autonomy.

In Malawi, the government has made a clear choice to move towards hospital autonomy starting with the two main referral and teaching hospitals in the country. The extent of autonomy, however, is bound by two key criteria that will impact implementation:

1. The hospitals' capacity to assume responsibility of their own operations with existing resources.
2. The degree to which the government is planning to deviate from its long standing promise of free and affordable hospital care.

Objectives of Implementing Autonomy in Malawi

The limited financial resources and the state of operational and structural decay of public hospitals in Malawi are the primary reasons behind the Ministry of Health and Population's decision to move closer to granting central hospitals their autonomy. Privatization of the public hospitals is a possibility, but doing so would be politically costly for three reasons. First, privatization would be perceived by the general population as reneging on the government's past assurances to provide free or low cost health care. Second, the central hospitals serve as the only teaching and referral institutions for the entire health care system. Third, the simple economics of income versus needs would mean that a majority of Malawians would be left without secondary and tertiary care under that scenario. A middle course that can help avoid these disadvantages is to continue to retain public ownership of the hospitals, but introduce organizational reforms that induce the hospitals to operate more efficiently, while continuing to meet most of the government perceived public duty.

STRATEGY

Overview

Malawi's Ministry of Health and Population (MOHP) would like to shift two government-owned central hospitals toward operational and possibly financial autonomy. It is envisioned that with more control over their budgets, personnel, and operations, the hospitals would have the incentive to increase efficiency and improve the quality of care. Nonetheless, the hospitals will continue to retain their primary social mission as inpatient tertiary facilities that provide affordable care to those unable to pay the full cost of their care.

The Partnerships of Health Reform's (PHR) assessment of Queen Elizabeth Central and Lilongwe Central hospitals indicated that these hospitals have limited control over their operations and insufficient financial and human resources. Based on the assessment and other studies commissioned by MOHP, and due to the increasing financial needs of the hospitals, PHR recommends that MOHP move forward with implementing a systematic plan to grant these hospitals more operational and financial independence.

This report outlines the recommended steps that MOHP needs to undertake to approach the implementation of hospital autonomy in an organized manner. Planning for implementation details the steps and issues that need to be addressed prior and during actual implementation of hospital autonomy.

Planning for implementation recommends developing an integrated-phased strategy that addresses regulatory, financial, and management issues and devising a plan that communicates the proposed activities to the hospitals, ministry, and other stakeholders who may impact implementation. Each of these activities will result in a specific output that is stated in this document.

In the areas of management and patient services, the underlying assumption is that changes in the practice of how the hospitals operate and provide care is required. Management restructuring must take place at two levels:

STRATEGY

- In the guiding relationship between the MOHP and the hospitals, and,
- Within the hospitals themselves.

At the first level, MOHP will transfer more decision-making powers to the directors of the hospitals. For example, in personnel issues this would mean that while the hospitals will continue to follow general government policies and regulations, they should be authorized to hire personnel as needed and outlined in their annual planning budget, reward employees for superior performance, and reprimand or dismiss staff if their work is unsatisfactory.

Clear lines of authority and responsibility will have to be outlined. These lines are currently blurred below the position of hospital director. This lack of clarity places too much emphasis for the success of the hospital on the abilities of the director alone.

Changing Outside Determinants of Hospital Performance

The outcome of hospital autonomy and reorganization depends to large extent on exogenous features of the hospitals' external environment as well as on characteristics of the reform process and of the hospitals themselves. The external determinants include the social and economic conditions that determine the demand for the hospital services and the existing policy structure which will not be changed by the autonomy process. Part of designing the hospital autonomy implementation plan is assessing the potential impact of these external factors, such as civil service laws and regulations. If it is perceived that one or more of these external factors can pose serious threat to the hospital reform process, a serious consideration must be given to whether or not it is possible to change these laws or arrange for the reformed hospitals to be exempted from their application.

STRATEGY

Integration of Implementation

The recommended hospital autonomy strategy is based on an integrated phased approach that ensures implementation in an organized systematic way. To be successful, many systems internal and external to the hospitals will have to be in place and functioning properly prior to the final phase of implementation. This will include personnel, hospital systems, new laws and regulations and ultimately the willingness and commitment to implement change. The integrated implementation strategy includes three phases with multiple activities to be performed simultaneously. Establishing the proper infrastructure for implementing hospital autonomy will be the focus of the plan. The three phases of implementation are as follows:

- **Phase I – Initiate strengthening of hospital systems and resources and strengthen the primary sector feeding the hospitals.**
 - < Strengthen the current capacity of the primary care system at the outpatient and rural health centers in order to absorb a larger number of the primary care patients and improve their services. This would comprise establishing a rotation system for specialists to visit the primary facilities on a regular basis and increasing the facilities' drug inventory from current levels through better utilization and inventory management.
 - < Develop referral system at the primary care outpatient clinics and district and rural hospitals and tie it to a utilization review system in order to ensure integrity of referrals to the central tertiary hospitals.
 - < Initiate a strategy of limited user fees at the hospital-based outpatient clinics to discourage primary care patients from using tertiary hospitals for routine illnesses that should be treated free at the rural and district hospitals and clinics.
 - < Implement in-depth assessment of human resources to assess the qualifications of the administrative and financial personnel and to determine training requirements.
-

STRATEGY

- < Determine training and placement needs for administrative and financial staff.
- < Develop bylaws for Board of Directors that details powers and responsibilities.
- < Initiate administrative, financial, procurement and human resources training.
- < Conduct needs assessment of the hospital's various administrative, financial, procurement and human resources systems (i.e., policies and procedures). The purpose is to determine the hospitals' needs as an autonomous government entity and ensure they are compatible with existing government accounting, purchasing and hiring guidelines.
- < Initiate mobilization of political support needed for phases II and III of implementing autonomy.
- < Appoint Board of Directors.
- < Prepare a list of all laws and regulations that impact the transfer of operational powers to the hospitals.

- **Phase II – Strengthen the central hospitals' operational capacity.**

- < Complete training of administrative, financial, procurement and human resources personnel.
 - < Implement detailed administrative, financial, purchasing and procurement policies and procedure systems.
 - < Initiate the transfer of operational authority to the hospitals in areas that do not conflict with existing laws.
-

STRATEGY

- < Draft and present to relevant political stakeholders (e.g., parliament and cabinet) a list of existing laws and regulations that will need to be changed before final control can be transferred to the hospitals.

- **Phase III – Complete the transfer of operational autonomy to the hospitals.**

- < Finalize all hospital administrative, financial, procurement, and human resources systems implementation.
- < Enact changes in laws that formally create by public act the autonomous hospitals and draw the boundaries of their relationships with other public organizations.
- < Design monitoring and evaluating system that measures the progress made under the hospital reform process.

In addition to the implementation strategy, two ongoing activities will overlap the three phases:

- Establish timeline for implementation to ensure that all strategic issues are considered and resolved.
 - Communicate the strategy's various points to all stakeholders.
-

IMPLEMENTATION - Phase I

It is estimated that 90 percent of all outpatient visits are for routine illnesses that should have been treated at a primary health center or at a lower level primary or secondary hospital. Furthermore, 20 to 30 percent of inpatient admissions at the central hospitals do not require admission to inpatient wards. The excessive use of the tertiary hospitals has had a heavy toll on the hospitals' already limited resources and limits their ability to make any significant changes towards improving patient care conditions. Any talk at the present time of implementing autonomy and improving efficiency will have no significance until both of these hospitals can decrease or limit their current utilization rates. The problem is magnified further after taking into consideration the increasingly limited human resources at both facilities.

The first step towards yielding more autonomy to the hospitals is by alleviating the pressure on their limited resources. The hospitals, however, do not operate independent of their surroundings and many of the factors that lead to the high utilization rates are beyond their control. The first phase of the implementation plan will be devoted partially to strengthening the primary health centers and other primary care facilities and to introducing new mechanisms that would provide incentives for the patients to use them.

1. **Physician Rotation** – One of the main reasons patients do not use health centers is the perception that they may not receive the same specialized care that they would receive at central hospitals. Largely, this is a true perception, because of the shortage of physicians. Primary health centers depend entirely on clinical officers and other non-physician personnel to provide care for their patients. To change that perception, primary health centers will have to start offering more services provided by the central hospitals' specialists. Taking into consideration the shortage in specialists, a rotation system will be developed and agreed upon with all concerned parties that would allow specialists to provide care on a routine basis at the primary health centers. The rotation system will have to take into consideration any transportation arrangements or other possible incentives for the physicians to commit to such visitation schedule.
-

IMPLEMENTATION - Phase I

Output – Create a system that outlines the guidelines for physician rotation to alternate physician visits to the health centers and guarantees coverage for these clinics on a weekly or biweekly basis. Physicians at the hospitals should approve the final plan prior to implementation.

2. **Referral System** – Having physicians providing care does not in itself guarantee attracting primary care patients to the health centers. Without a referral system that can monitor and control referrals from the primary and secondary providers to tertiary providers, central hospitals will not see much of a decline in utilization rates. The purpose of the referral system is to install guidelines for the cases that require referral to the central hospitals. The referral system will be implemented in conjunction with penalties for providers who do not comply by the guidelines. In other words, there will have to be a utilization management system in place that can monitor the referral patterns for the various providers.

Output – Develop a detailed system that outlines guidelines that should be followed at the primary and secondary level facilities for referring patients to the tertiary level central hospitals. The system should be accompanied by a complete utilization review plan that monitors referral patterns.

3. **User Fees** – To encourage patients to obtain their primary health care needs at the health centers instead of referral hospitals, a user-fee schedule for primary services should be instated at the central hospitals. The fee schedule would cover only those services that could otherwise be obtained at the health centers. Although patients at the paying outpatient department and the paying inpatient wards currently are charged a fee for some of these services, these charges account for only a fraction of the actual cost and do not act as a deterrent from using central hospitals as primary care providers. The following are some of the important issues that need to be taken into consideration during implementation of the user fees:
 - The proposed charges will have to be close to the actual cost if they are to have any effect on changing patients' utilization behavior.
-

IMPLEMENTATION - Phase I

- Although currently actual costs cannot be estimated due to the lack of cost accounting, costing estimates could still be made using the step-down method to cost hospital-based services rather than waiting for the cost accounting system to be installed.
- The proposed fee schedule should only be implemented following the installation of the physician rotation and referral systems.
- To be able to track the new stream of revenue, existing accounting procedures will need to be one of the first hospital systems to be operational.
- Revenue generated from user fees should be reinvested in the hospitals.

Output – Conduct a complete study with recommendations detailing which primary care services should institute charges at the central hospitals. The recommendations should include a fee schedule that details various charges applied to each service.

The first three proposed activities under Phase-I deal primarily with improving the capacity and quality of the primary health providers. The following proposed activities deal mainly with improving the existing organization and systems at Lilongwe and Queen Elizabeth Central hospitals in order to increase their capacity to be autonomous hospitals.

- 4. Staff Assessment, Training, and Placement** – The hospital assessment indicated that there is no consistency in the qualifications and skills of staff in the same positions at the two central hospitals. Although the assessment was not targeted to look specifically into personnel issues, since the success of the proposed activities will ultimately rely on the people who implement them, it is absolutely necessary to have qualified, motivated, and creative staff who are willing and able to take on more responsibility.

The purpose of the staff assessment will be to decide on the training and placement needs of the existing administrative and financial personnel. Since the hospitals presently cannot lay off unqualified staff, MOHP will have to play a role in placing the expendable staff in other MOHP facilities and replacing them with more qualified staff from other MOHP units.

IMPLEMENTATION - Phase I

Training will be based on the assessment findings. Training should only include those staff members who are envisioned to continue working with the hospitals following the reorganization. It will cover topics such as financial management, hospital administration, and human resources management among other issues.

Output – Conduct a complete assessment of administrative and financial personnel at the two central hospitals. This detailed plan should outline training needs and placement recommendations.

5. **Hospital Management Systems Needs Assessment** – The hospital management systems refer to the availability of management systems that organize the daily operations at the central hospitals. They are the policies and procedures that outline the steps that staff should follow while performing their duties and functions. These systems define internal relationships between the various hospital departments and external relationships that regulate how the hospitals interact with their outside environment. The systems are what bring together the various inputs and generate a cohesive unit that provides quality care to its patrons. Without these systems, the components of the hospital would act incohesively and would waste valuable resources. The purpose of the needs assessment is not to assess the current systems and recommend changes but to assess the need to establish new policies and procedures that can enhance the functionality of the two hospitals and satisfy the requirements for increased autonomy.

Output – Prepare a comprehensive assessment and development of the hospital management systems needs, particularly in the areas of finance, human resources, patient registration, and admissions.

IMPLEMENTATION - Phase I

6. **Build Commitment** – The current situation in the central hospitals requires dramatic changes in the way hospitals operate and provide care. Such changes may not be easy to make, and there is no doubt that some of the proposed changes may require Malawi policy makers to make some difficult decisions.

The option, of course, is to make superficial changes that give temporary solutions but do not touch on the core problems. It is therefore important to build support at the various stakeholder levels – those who are responsible for making the changes and others who will be affected directly by them. Building the needed support and commitment for change will be an ongoing activity throughout the three phases of implementation. It is necessary, however, to start working on building support very early on in the process since many of the proposed changes will not take place or will have no value if there is not enough commitment to continue.

Output – Establish immediate ongoing contact with the policy makers who will be responsible for approving the proposed changes, communicate the potential impact of hospital autonomy on the quality of care, and secure their support.

7. **Initiate Training** – Initiate training based on the findings from the personnel assessment. The training provided would vary depending on the function, intensity, and person to whom it is provided. The purpose of the training is to increase the skill and knowledge level of the administrative, financial, and other hospital staff, some of who will be adding on new responsibilities or may not have been qualified for their existing jobs. Training should only be provided to those staff members who have demonstrated a desire to learn and willingness to accept new responsibilities.

Output – Implement various training plan components.

IMPLEMENTATION - Phase I

- 8. Develop Board of Directors Bylaws and Appoint First Board** – Develop the policies and procedures for appointing the board of directors. The bylaws should detail among other things number of board members, qualifications, powers, term limits, method of appointment or election, responsibilities, number of meetings, appointing various committees and voting procedures. Following the finalization of the bylaws manual, the first board of directors should be appointed in accordance to the bylaws.

Output – A complete board of directors bylaws manual.

IMPLEMENTATION - Phase II

During this phase, the emphasis will be on implementing organizational and personnel changes at the two central hospitals. The objective is to have a transitional period during which the hospitals can adapt to the newly introduced systems. The systems will include a new organizational structure that delineates authority, responsibility, and accountability. This will require a clarification of the mission of the hospitals, delegation of responsibilities, and an upgraded role for the administrative and financial personnel. To achieve these objectives, an increase in the skill level of the administrative personnel will be necessary. The two primary methods that can be used to increase personnel skills are to train existing staff and attract new qualified staff from elsewhere within the MOHP. The principal objective of using these methods is to integrate and align the organizational and employee needs.

1. **Complete Training** – Complete the training of the hospitals' personnel. The training provided would vary depending on the function, intensity, and person to whom it is provided. The purpose of the training is to increase the skill and knowledge level of the administrative, financial, and other hospital staff, some of who will be adding on new responsibilities or may not have been qualified for their existing jobs. Training should only be provided to those staff members who have demonstrated a desire to learn and willingness to accept new responsibilities.

Output – Implement various training plan components.

2. **Placement** – Placement in this context means the transfer of expendable staff to other hospitals or MOHP units and attracting other individuals who fit the needs of these positions. Transfers would take place only if the personnel assessment indicated a need to do so and would serve only as an interim solution since discharge of employees is virtually impossible. MOHP does not emphasize in its hiring the need to match the right skills with the proper position and, in many cases, the individual assigned to a specific job is not qualified to do that job. The hospitals, however, have no authority and have to accept these individuals.
-

IMPLEMENTATION - Phase II

Existing government policies make it almost impossible to dismiss staff. As a result, until hospitals have full authority over all personnel actions, it is important that they secure MOHP support in transferring and attracting individuals from inside the MOHP system.

Output – Initiate transfers from and to the central hospitals and other MOHP units.

3. **Implement Hospital Systems** – Once the systems are developed based on the needs assessment completed during Phase-I, the hospitals will start implementing them with properly trained staff. In the case of the finance department in particular, reporting and auditing requirements will be a challenging task for the central hospitals. Changes in financial management will be necessary before the hospitals can do the following:

- Develop new budgetary processes;
- Account and track the various sources of revenue;
- Adjust to changes in procurement, maintenance, and inventory control management;
- Adapt to changes in personnel policies; and
- Establish audit and reporting requirements.

The objective of establishing new policies and procedures is to enhance the functionality of the hospitals as they prepare to acquire new responsibilities that will come with being autonomous. The hospitals will need to have enhanced management, planning, reporting, and tracking systems in place; otherwise, they will not have the capacity or the capability to manage their own affairs.

Output – Establish policies and procedures for administrative and financial services that are followed by other hospital support and patient services.

IMPLEMENTATION - Phase II

4. **Initiate Transfer of Authority and Responsibility to Hospitals** – There are certain administrative functions that can be immediately transferred to the hospitals once training is completed and staff has been trained. Transferring these primarily functions to the hospital director would not conflict with existing laws and regulations, and this can be enacted by simple decree from the Minister of Health. Initiating the transfer of these functions will facilitate the smooth transition of full operational autonomy to the hospitals.

Output – Initiating the first set of transfer of operational powers from the central level to the hospital level.

5. **Draft Proposed Changes to Laws and Regulation** – The final step under Phase II is to present to policy makers a list of specific proposed changes to the existing laws and regulations. These changes should formally shift to the hospitals many of the existing powers that are currently being held elsewhere. Implementing autonomy is not in itself the objective, but rather is the means to improve the efficiency and quality of patient care. This goal should be the driving force when deciding which of the existing laws and regulations restrict the hospitals' ability to manage their operations effectively. The change in regulations could possibly alter the status of the central hospitals, making them fully autonomous government entities or merely typical MOHP hospitals with slightly more authority than other MOHP facilities. Either way, the decision to change should be based on what will allow the hospitals to be more efficient while ensuring that their poor patient base continues to receive quality affordable care.

Output – Implement hospital-wide administrative and financial policies and procedures.

IMPLEMENTATION - Phase III

The final phase of the plan deals with the actual implementation of autonomy, giving the hospitals the legal right to manage their own operations. By the time the two central hospitals reach this point, the following prerequisites should be in place:

- **Administrative and financial management systems are operated by competent staff.**
- **The hospitals have established a reporting mechanism that sends accurate information to the MOHP or the entity responsible for overall hospital performance.**
- **The hospital director has established “executive limitations” against which he or she can be held accountable.**
- **All changes to existing laws and regulations, necessary to enhance the hospitals’ ability to manage their own operations, have been made.**
- **A monitoring and evaluation system that establishes a relationship between the intervention “organizational reform” and the impact “performance enhancement” has been implemented.**

The objectives of this phase are to develop a coherent strategy within which the central hospitals will operate, ensure they will receive core funding through block grants, either conditional or unconditional, and coordinate the activities of the central hospitals with those at the primary care level.

Evaluation

The purpose of evaluating hospital autonomy is to determine whether the hospitals’ performance has improved as a result of the reform process. Changes produced by the hospital autonomy process should be measured against five dimensions:

- Technical efficiency,
 - Quality,
 - Equity
-

IMPLEMENTATION - Phase III

- Allocative efficiency, and
- Organizational performance.

Since hospital autonomy and reorganization take place in a diverse environment, there are many other influences on hospital performance in addition to the reform process itself. The most challenging aspect of evaluating those reforms will be to infer what would have happened in the absence of reform. Any evaluation of a policy experiment requires taking into consideration the so-called “counterfactual”; that is, what would have happened to the same hospitals in the absence of the reform.

Outcome -- Establish decentralized decision making with regards to the following:

- **Strategic management**
 - **Procurement**
 - **Financial management**
 - **Human resources management**
 - **Administration.**
-

COMMUNICATIONS

Much of the success of implementing hospital autonomy depends on the support and consent of entities outside the control of the MOHP. As a result, this issue is very sensitive and requires a great amount of discretion. To increase the odds of success, it will be important to develop a communications strategy that addresses the concerns of the various stakeholders. These stakeholders should include, but not be limited to, the following:

- Policy makers
- MOHP
- Hospital patrons.

Developing and implementing a communications strategy will not be a one-time activity. Rather, it will continue throughout the five years of project implementation. For the stakeholders to have ownership in the process, they will need to be continually updated and consulted on the implementation's progress.

Working with the Policy Makers

Policy makers are probably the most influential group of stakeholders in the hospital autonomy implementation plan. Many of the proposed activities will require serious changes in how the hospitals operate and provide care, and without the strong support of Malawi policy makers, these changes will not happen. Before they give their support, policy makers will have to feel comfortable that these changes not only will maintain the social mission of these hospitals but also will produce a visible improvement in how care is provided.

Working with MOHP

Hospital autonomy activities in most countries place the MOHP in an awkward predicament in that, in essence, their end result will be that MOHP surrenders much of its control and clout in the most visible symbol of the country's health care system – the hospital. Undoubtedly, MOHP has a direct stake in the outcome of the implementation plan. For this reason, it is recommended that a high-level independent committee be appointed to take full responsibility of

COMMUNICATIONS

implementation, with direct reporting responsibilities to the cabinet's high committee on health care. This does not lessen the role the MOHP plays in implementation; it does, however, neutralize it. With the different activities that are expected to transpire during the transition period, and the likely formation of many joint task forces charged with managing the transfer of responsibility, it is vital that expert staff from MOHP be constantly involved in all design and implementation stages of hospital autonomy.

Working with the Public

The ultimate goal of providing hospitals with more autonomy is to improve performance and increase patient satisfaction with the level of care. This would not be feasible without rationalizing resources and shifting some of the cost burden to the patient. The result will be that patrons receive a higher quality of care while increasing their responsibility in sharing the costs. The alternative would be to stay with the status quo, making it practically impossible to maintain even the minimum acceptable level of quality care. A communications plan targeted to the public must emphasize that changes at the central hospital level will mean not only improved tertiary care but expanded and improved services at the primary level facilities as well.

Output – Develop an ongoing communications strategy to update, consult with, and include various stakeholders at all phases of hospital autonomy implementation.

TIMELINE FOR KEY STEPS











The following proposed implementation timeline should be treated as a general guide for the sequence of implementation. It takes into account expected required time to start and finish certain tasks. However, unexpected outside factors that may impact implementation schedule are not taken into account. These outside factors can either speed up or delay implementation which, in turn, will have to be modified in order to take them into account.




The implementation of hospital autonomy is a multi-task and multi-activity process that will require certain activities to be completed or started before others can commence. Nonetheless, the pace and commitment to execute the various tasks are the main factors that will dictate implementation speed and effectiveness.

The proposed timeline is based on logical sequence of activities. However, depending on the priorities of the MOHP and the hospitals, some of the sequence may be altered. For example, the main reason a large portion of Phase-I is devoted to strengthening the primary outpatient system is due to the large amount of the hospital's limited resources that go into treating patients that could have been treated elsewhere. Nevertheless, if the MOHP and the hospitals felt that it is more important for them to work on designing new administrative policies and procedures first, then they may alter the sequence of implementation knowing that much of the hospital resources still goes into services that should have been provided elsewhere.

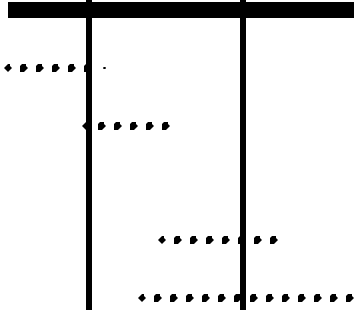


In summary, even though we recommend that the hospitals follow the recommended order of implementation, it is plausible that the order may be changed but with likely impact on the schedule.

Timeline and Order of Implementation

TASKS	'01	'02	'03	'04	'05
Preliminary Stage: <ul style="list-style-type: none"> MOHP to finalize and agree on implementation plan and key steps. <ul style="list-style-type: none"> Agree on plan with the Hospital Autonomy Working Group. Meet with the Minister of Health. Secure initial support from main political stakeholders (Cabinet Committee on Health Care, Parliament, etc.) <ul style="list-style-type: none"> Develop a list of the main political stakeholders who will need to approve the plan. Meet with the key providers to present plan and secure initial commitment for support. Communicate general plan outline to key staff at the hospitals, MOHP, and directors of the health centers and seek their support. Establish a high-level executive implementation committee with a mandate to take responsibility of all implementation activities. Agree on the limitations to the executive authority of the hospital directors during and at end of implementation of hospital autonomy. 	    				
Phase I: Initiate activities to strengthen the hospital systems and resources and strengthen the primary sector <ul style="list-style-type: none"> Design and implement a rotation system for specialists at the health centers. <ul style="list-style-type: none"> Assess current and future needs at the health centers and rural hospitals. Design a rotation system with input from the physicians. Secure transportation and other potential incentives for physicians. Communicate new policy to the MOHP. Develop communications plan to inform the public of the new changes. 	    				

TASKS	'01	'02	'03	'04	'05
<ul style="list-style-type: none"> - Implement new rotation system. 				
<ul style="list-style-type: none"> • Design and implement a patient referral system. <ul style="list-style-type: none"> - Develop a list of all primary care diagnostic services that should be treated at the primary level facilities. - Establish complete guidelines and protocols for treatment and referral with input from primary care and specialist physicians. - Train practicing physicians at the primary level on these guidelines. - Set up a utilization management department, with dual reporting duties to the hospital directors and MOHP to review referrals and track specific provider referral patterns. - Train clinical officers at the central hospitals to operate the utilization review department. 					
				
			
				
				
				
				
				
<ul style="list-style-type: none"> • Establish a comprehensive user fee schedule for primary care services provided at the central tertiary hospitals. <ul style="list-style-type: none"> - Develop a list of all primary care services provided at QECH and LCH. - Estimate the actual cost of these services based on a step-down method. - Secure the necessary approvals from key stakeholders to introduce full cost user fees for those primary services that can be obtained elsewhere at the primary delivery level. - Upgrade accounting system to track locally generated revenue. 					
			
				
				
				
				
				
				
				
<ul style="list-style-type: none"> • Conduct a comprehensive assessment of administrative and financial staff; decide on training needs and necessary staff transfers. <ul style="list-style-type: none"> - Decide on all administrative staff that the assessment will cover. - Agree on criteria for evaluating staff. - Present detailed training plan that includes the “who, what, and how.” - Secure approval for the training plan and secure financing from international donors. 					
	...				
	...				
				
				

TASKS	'01	'02	'03	'04	'05
<ul style="list-style-type: none"> - Present recommendations of the necessary staff transfers. - Secure MOHP approval and support for the placement plan. • Conduct hospital management systems needs assessment. <ul style="list-style-type: none"> - Determine future needs in the following areas: ♦ Strategic management ♦ Procurement ♦ Financial management ♦ Human resources management ♦ Administration <ul style="list-style-type: none"> - Develop complete management with systems and policies and procedures. • Develop board of directors bylaws and appoint board. • Build political support and commitment with key stakeholders including: <ul style="list-style-type: none"> - Politicians - Cabinet - MOHP - Central hospitals - Public 		<p>.....</p> <p>.....</p>			
<p>Phase II: Implement training and placement requirements and establish hospital administrative and financial systems. Present proposed changes to existing laws and regulations.</p> <ul style="list-style-type: none"> • Implement training programs at the various administrative and financial levels of the hospital based on the training plan developed under the staff assessment. • Implement recommendations regarding staff transfers between the central hospitals and various MOHP units. 					
<ul style="list-style-type: none"> • Put into operation the newly designed hospital systems including new policies and procedures in the following areas: <ul style="list-style-type: none"> - Strategic management - Procurement 					

TASKS	'01	'02	'03	'04	'05
<ul style="list-style-type: none"> - Financial management - Human resources management - Administration 					
<ul style="list-style-type: none"> • Present proposed changes in laws and regulations to MOHP and the Cabinet Committee on Health. <ul style="list-style-type: none"> - Compile a list of all laws and regulations that impact the hospital's operations. - Decide on laws and regulations that will need to change in order for the hospitals to have more administrative autonomy. - Communicate desired changes to various policy makers and include their inputs. - Prepare and present final document detailing new proposed legislation. <p>Phase III: Issue legislation officially conceding new authorities to the hospitals and designating them as autonomous.</p> <ul style="list-style-type: none"> • Complete transfer of operational autonomy at hospitals such as hiring, budget preparation, dismissal, procurement, etc. • Establish an evaluation system to monitor the implementation and impact of the hospital autonomy on the hospital's performance. 					

Annex B: Bibliography

Acobat, Gani. 1996. *Improving Quality in Public Sector Hospitals in Indonesia*, International Journal of Health Planning and Management, 11 (1996) 275-296.

Achouri, H., Jarawan, E., November 1998. *Innovations in Delivery of Health Care Services*, World Bank Case Study. Washington, DC: The World Bank

Banks, D, Shehata, I.. March 2000. *Implementing Hospital Autonomy in Jordan: Changing MOH Operating Procedures*. Bethesda, Maryland: Partnerships for Health Reform Project, Abt Associates Inc.

Barnum. H., Kutzin, J. 1993. *Public Financing in Developing Countries: Resource Use, Cost and Financing*. Baltimore, MD: John Hopkins Press.

Chawla, M., Govindaraj, R., Berman, P., Needleman, J. August 1996. *Improving Hospital Performance through Policies to Increase Hospital Autonomy: Methodological Guidelines*. Boston, MA: Data for Decision Making Project, Harvard University.

Chawla, M., Govindaraj, R. 1996. *Recent Experiences with Hospital Autonomy in Developing Countries – What Can we Learn?* Boston, MA: Data for Decision Making Project, Harvard University.

Collins, D., Njeru, G., Meme, J. June 1996. *Hospital Autonomy in Kenya: The Experience of Kenyatta National Hospital*. Boston, MA: Data for Decision Making Project, Harvard University.

Department for International Development. October 26, 1998. “Central Medical Stores Reform, Malawi.” DFID document

Douglas, H.R. 1994. *Autonomous Hospitals in Zambia: A Proposal for Evaluation*, M.Sc. Health Services Management Health Policy Report. London, U.K.: London School of Hygiene and Tropical Medicine.

Govindaraj, R., Oboudi, A.A.D., Enyimayew, A.K.A., Antwi, P. August 1996. *Hospital Autonomy in Ghana: The Experience of Korle Bu and Komfo Anokye Teaching Hospitals*. Boston, MA: Data for Decision Making Project, Harvard University.

McPake, B. 1996. *Public Autonomous Hospitals in Sub-Saharan Africa: Trends and Issues*, Health Policy 35 (1996) 155-177.

McPake, B. and Ngalande Banda, E. 1994. *Contracting Out of Health Services in Developing Countries*, Health Policy and Planning, 9(1) (1994) 25-31.

Mills, A.J., Vaughan, J.P., Smith, D.L., and Tabibzadeh, I. 1990. *Health System Decentralization: Concepts, Issues and Country Experience*. Geneva, Switzerland: World Health Organization.

Ministry of Health and Population. August 1999. *Malawi National Health Plan 1999–2004: V.3, Health Sector Human Resources Plan*. Lilongwe.

Ministry of Health and Population, Human Resources Team. September 1997. *Human Resources in Support of Implementing Essential Health Care Package in Malawi*. Lilongwe.

Nkosi, M.W. Venge (program economist, USAID/Lilongwe). January 1998. *Government of Malawi: Budgetary Process: Preparation, Monitoring and Control*. Lilongwe.

Weinberg, J. April 1993. *The Development of Independent Hospital Boards, Report of a Study Visit to The Gambia and Ghana*, carried out on behalf of Overseas Development Administration. London, U.K.

